

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-042905

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5928

STATE FILE NUMBER

FILED DEC 10 1962

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 1 YEAR		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL		d. STREET ADDRESS (If outside, give location) 4746 ROANOKE PARKWAY	
3. NAME OF DECEASED (Type or print) First LEO Middle C Last SCHELLHORN		4. DATE OF DEATH Month NOVEMBER Day 23 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/21/1900
9. AGE (last birthday) 62		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE MANAGER		10b. KIND OF BUSINESS OR INDUSTRY NEW YORK LIFE INSURANCE CO.	
11. BIRTHPLACE (City and state or country) ST. JOSEPH, MO.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME JOHN A. SCHELLHORN		13b. MOTHER'S MAIDEN NAME BERTHA HAUSER	
14. NAME OF HUSBAND OR WIFE MRS. ESTHER SCHELLHORN		Address 4746 ROANOKE PKY. KANSAS CITY, MO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----	
17. INFORMANT ESTHER SCHELLHORN		Address 4746 ROANOKE PKY. KANSAS CITY, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Tachycardia. DUE TO (b) Body fluid chemical imbalance DUE TO (c) Surgery for ulcerative colitis on Nov 13, 1962; and Surgery for intestinal obstruction on Nov 22, 1962		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Previous myocardial infarction 1958		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 1:30 a.m. 2:30 p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION ST. LOUIS COUNTY MISSOURI STATE MISSOURI	
21. I attended the deceased from March 1962 , to Nov 23, 1962 and last saw her/him alive on Nov 23, 1962 Death occurred at 1:30 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE William F. Sanders M.D.		22b. ADDRESS 411 Michala Blvd K.C. Mo.	
22c. DATE SIGNED 11/23/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE NOV. 26, '62	23c. NAME OF CEMETERY OR CREMATORIUM NEW PICKEN CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 11-24-62	26. REGISTRAR'S SIGNATURE Arthur Long

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

William F. Sanders, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/591
2 3729
34 0
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8 1

9 572.2

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12 66-0

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Dr. Sanders
1024 West 6.6th Avenue

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Edward M. Strong

Licensed Embalmer No. _____

4452

P. O. Address

K. C. 10 Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting:

If this body is not embalmed, fact should be so stated above.